STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 121284-001-SF**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 17th day of October 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On May 10, 2011, XXXXX (Petitioner) filed a request with the Commissioner of Financial and Insurance Regulation for an external review under Section 2(1)(b) of Public Act No. 495 of 2006, MCL 550.1951 *et seq*. The Commissioner reviewed the request and accepted it on May 17, 2011.

The Petitioner receives group health care benefits under the State of Michigan Health Plan PPO, a self-funded government plan as defined in Section 1 of Act 495, MCL 550.1951. The plan is administered by Blue Cross Blue Shield of Michigan (BCBSM). Under Section 2(2) of Act 495, MCL 550.1952(2), the Commissioner conducts this external review as though the Petitioner was a covered person under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq*.

The Commissioner immediately notified BCBSM of the request for an external review and asked for the information it used to make its final adverse determination. The Commissioner received BCBSM's response on May 24, 2011.

The issue in this external review can be decided by a contractual analysis. The Petitioner's benefits are defined in the State of Michigan *State Health Plan PPO Your Benefit*

Guide (the benefit guide). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On June 16, 2010, the Petitioner was transported by ground ambulance from the XXXXX Hospital in XXXXX to XXXXX Medical Center Rehabilitation in XXXXX.

The ambulance service's charge for the transport was $1,328.10. BCBSM denied coverage, stating the transportation did not meet the criteria of the benefit guide.

The Petitioner appealed BCBSM's denial through its internal grievance process. BCBSM held a managerial-level conference on March 2, 2011, and issued a final adverse determination dated March 29, 2011.

III. ISSUE

Is BCBSM required to cover the Petitioner's ambulance transportation of June 16, 2010?

IV. ANALYSIS

Petitioner's Argument

On May 22, 2010, the Petitioner suffered a stroke and was flown from XXXXX to the XXXXX Hospital (XXXXX) for treatment. The Petitioner was in intensive care for three weeks and was then told she needed inpatient rehabilitation. Arrangements were made for her to go to XXXXX Medical Center Rehabilitation close to her home in XXXXX. The Petitioner's husband explained the reason and need for the ambulance transport:

> We were given the choice of waiting at XXXXX for an opening in their program, or going back home to XXXXX and attending rehab there. We choose [*sic*] to go to XXXXX rehabilitation in XXXXX.
>
> On 6-16-10, [the Petitioner] was transported . . . from XXXXX to XXXXX. This transport was medically necessary due to her condition.
>
> While this transport may not have fallen under the narrow guidelines of our health insurance plan. [*sic*] It was economically beneficial to BCBSM. Had we remained at XXXXX for rehabilitation, the cost would have overshadowed the cost of the transport.

BCBSM's Argument

In its March 29, 2011, final adverse determination, BCBSM informed the Petitioner's husband of the basis for its denial:

> Your coverage does not pay for transportation for the convenience of the patient, the patient's family or the preference of the physician.
>
> Because your wife was not transported to the nearest skilled nursing facility capable of treating her, but rather the XXXXX Medical Center in XXXXX, payment cannot be approved.

BCBSM does not deny that transportation by ambulance was medically necessary but states that XXXXX was not the nearest facility.

Commissioner's Review

Ambulance transportation is covered if it meets certain criteria. The benefit guide (page 16) states:

> - **Professional ambulance services —** Ambulance services are covered if the destination is the nearest medical facility capable of treating the patient's condition.
>
> The service must be:
>
> — Medically necessary because transport by any other means would endanger the patient's health
>
> — Prescribed by a physician (when used for transferring a patient)
>
> — Provided in a vehicle qualified as an ambulance and part of a licensed ambulance operation
>
> * * *
>
> Your coverage does not pay for transportation for the convenience of the patient, the patient's family or the preference of the physician.

BCBSM states that its medical consultant reviewed the ambulance report and concluded that ambulance transportation was "approved," i.e., medically necessary, for the Petitioner. [1] BCBSM did not state that it was not prescribed by a physician or that the ambulance was not part of a licensed ambulance operation. Thus, the only issue here is whether the transport was to "the nearest medical facility capable of treating the patient's condition."

1 BCBSM's May 24, 2011, response to the external review request.

In order to assert that the Petitioner was not taken to the nearest appropriate facility, BCBSM must minimally identify another facility that would have met the Petitioner's needs. There is nothing in the record to show that the XXXXX Medical Center Rehabilitation in XXXXX was not the "nearest medical facility capable of treating the patient's condition." Because BCBSM acknowledged that ambulance transportation was medically necessary but failed to support its assertion that there was a closer facility where the Petitioner could have been taken, the Commissioner overturns BCBSM's denial of the ambulance claim.

V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of March 29, 2011, is reversed. BCBSM shall cover the Petitioner's June 16, 2010, ambulance transportation within 60 days of the date of this Order and shall, within seven (7) days of providing coverage, furnish the Commissioner with proof it has implemented this Order.

To enforce this Order, Petitioner may report any complaint regarding implementation to the Office of Financial and Insurance Regulation, Health Plans Division, toll free (877) 999-6442.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.